BEFORE COMPLETING, SEPARATE INTO 2 FORMS BY REMOVING STAPLE.

INCIDENT, ACCIDENT, ILLNESS, DEATH OR FIRE REPORT
STATE OF MICHIGAN
Department of Human Services
Office of Children and Adult Licensing

INSTRUCTIONS

- **The completion of this form may optionally be used to document the requirements of the following licensing rules:**

  Child Care Centers R 400.5111, R 400.5865
  Children's and Adult Foster Care Camps R 400.11227
  Child Placing Agencies R 400.12415 (2)
  Child Caring Institutions R400.4167(1)(2)
  Juvenile Facilities R400.10159(2)
  Family and Group Child Care Homes R400.1808(1)(2)

- **The completion and submission of this form to the Agency is required by the following licensing rules:**

  Child Care Centers R 400.5111 (2)
  Children's and Adult Foster Care Camps R 400.11127 (6)

FACILITY/HOME/PROVIDER:

License Number	Facility/Home/Provider Phone Number ( )		FACILITY TYPE:
Facility/Home/Provider Name			☐ Child Care Home ☐ Child Care Center ☐ Camp ☐ Child Caring Institution ☐ Juvenile Detention
Address (Street Number and Name)		County	
City	State	Zip Code	

LICENSING CONSULTANT:

Licensing Consultant Name

PERSON(S) IN CARE INVOLVED:

Name		Name	
Age	Sex ☐ M ☐ F	Age	Sex ☐ M ☐ F
Home Address If Other Than Facility/Home Address (Street Number & Name)		Home Address If Other Than Facility/Home Address (Street Number & Name)	
City / State / Zip Code		City / State / Zip Code	
Home Phone Number If Other Than Facility/Home ( )		Home Phone Number If Other Than Facility/Home ( )	
Name of Parent (if minor)	Work Phone Number ( )	Name of Parent (If Minor)	Work Phone Number ( )

OTHER PERSON(S) INVOLVED / WITNESS(ES):

Name	Name
Address (Street Number and Name)	Address (Street Number and Name)
Phone Number ( )	Phone Number ( )

DISTRIBUTION:

CHILD PLACING AGENCY:
Part 1 - Licensing Consultant (if required by rule)
Part 2 - Referring Agency

CHILD CARING INSTITUTION:
Part 1 - Licensing Consultant (if required by rule)
Part 2 - Resident Record

JUVENILE FACILITY:
Part 1 - Licensing Consultant
Part 2 - Referring Agency

FAMILY AND GROUP CHILD CARE HOME:
Part 1 - Licensing Consultant (if required by rule)
Part 2 - Home Record

CHILD CARE CENTER:
Part 1 - Licensing Consultant (if required by rule)
Part 2 - Center Record

CHILDREN'S AND ADULT FOSTER CARE CAMP:
Part 1 - Licensing Consultant (if required by rule)
Part 2 - Camper's Record

The Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your county.

AUTHORITY: P.A. 116 of 1973
COMPLETION: Voluntary/Mandatory
PENALTY: May be in violation of administrative rule.

PERSON(S) NOTIFIED:

Name of Person Notified	Notification Date	Notification Time	Non-Applicable
Physician		☐ A.M. ☐ P.M.	☐
Referring/Responsible Agency **(Child Caring Institution Only)**		☐ A.M. ☐ P.M.	☐
Probate Court **(Juvenile Detention Only)**		☐ A.M. ☐ P.M.	☐
Law Enforcement Agency		☐ A.M. ☐ P.M.	☐
Fire Marshal		☐ A.M. ☐ P.M.	☐
Local Coroner		☐ A.M. ☐ P.M.	☐
Family Member		☐ A.M. ☐ P.M.	☐
Other (Specify)		☐ A.M. ☐ P.M.	☐

Incident, Accident, Illness, Death or Fire				
Date:	Time: ☐ A.M. ☐ P.M.	Location:		
Description, Cause, Surrounding Circumstances				

	N/A
If Fire, State Extent of Damage	☐
First Aid Given and When, if Applicable	☐
Who Provided First Aid, if Applicable	☐
Other Action Taken	
Physician's Diagnosis of Injury or Illness, if Applicable	☐
Name of Treating Physician, Medical Facility, Hospital, if Applicable	☐
Phone Number of Treating Physician, Medical Facility, Hospital, if Applicable	☐
Cause of Death, if Applicable / Was an Autopsy Performed ☐ Yes ☐ No	☐

Were Any Handicaps, Health Problems, or Exceptions Listed on the Child's Health Records?
☐ Yes ☐ No

Signature of Person Completing This Report	Title	Date
Signature of Licensee/Responsible Person	**Title**	**Date**